SACRAMENTO ORTHOPEDIC CENTER
2801 K Street, Suite 330
Sacramento, CA 95816
(916) 733-5049

WORKERS COMPENSATION

Michael W. Leathers, MD	Lic.# G368320	Alan M. Hirahara, MD, FRCS{C}	Lic.# A674960
Timothy P. Mar, MD	Lic.# G537190	Patrick J. McGahan, MD	Lic.# A104904
Harold B. Strauch, MD	Lic.# A191960		

PCP: _____ DATE: _____

PATIENT INFORMATION

NAME: SOCIAL SECURITY NO:

STREET ADDRESS:

CITY: STATE: ZIP:

HOME PHONE: ( ) WORK: ( ) CELL: ( )

DATE OF BIRTH: AGE: ☐ MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ OTHER

REFERRING PHYSICIAN: PHONE: ( )

EMERGENCY CONTACT FRIEND / RELATIVE: PHONE: ( )

DRUG ALLERGIES:

EMPLOYER INFORMATION (AT TIME OF INJURY)

NAME OF EMPLOYER: OCCUPATION:

STREET ADDRESS:

CITY: STATE: ZIP:

CONTACT NAME: PHONE: ( )

WORKERS COMPENSATION CLAIM INFORMATION

DATE OF INJURY: PHYSICAL AREA OF INJURY:

NAME OF COMP CARRIER: CLAIM NUMBER:

MAILING ADDRESS:

CITY: STATE: ZIP:

CONTACT NAME: PHONE: ( )

FOR OFFICE USE ONLY

DATE:	UPDATED INFORMATION:	SOC EMPLOYEE:
DATE:	UPDATED INFORMATION:	SOC EMPLOYEE:
DATE:	UPDATED INFORMATION:	SOC EMPLOYEE:

INSURANCE AUTHORIZATION AND ASSIGNMENT

I herby authorize my insurance benefits be paid directly to physician, and authorize the release of any information necessary to process this claim. A copy of this authorization shall be as valid as original.

X _____ _____

Signature of Insured/Authorized Person Date